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Breaking the chains

Pakistan is a developing country and thereby burdened with the problems that all developing countries share. There are over 13 million people suffering from mild to severe mental disorders and with barely 200 psychiatrists throughout the country, the mental health services remain painfully inadequate and poorly developed. Both psychiatrists and psychiatric services are restricted to the major cities and, therefore, the 70% of the population that live in the rural areas have almost no access to modern day psychiatric facilities. Their only hope remains, as has been for centuries, with the local quack and faith healer.

The local beliefs regarding mental illness are strange and persistently unchanged. Mental illnesses are considered, without exception, to be a consequence of possession by the evil spirit, effect of magic spells, etc. Not surprisingly, therefore, it is the local faith healer or quack who is promptly approached for assistance. While some of the procedures practised by these local 'healers' are harmless, for example reciting holy verses etc., there are others that are, to say the least, horrific. The latter include, among others, scalp lacerations and blood letting using specially designed metal instruments, scalding of the face with hot iron, chaining to trees, beating, etc. Tragically these inhuman practices continue unabated even today, and on no small scale.

The human zoo

Chaining people with mental illness to trees around holy shrines is a practice that is still in use in different parts of the country. One such shrine is that of Dewan Sahib, some 300 miles south of Lahore. This shrine, according to local belief, provides 'cure' to people suffering from all forms of mental disorders on account of the blessings of the saint buried there. For centuries people from far-flung areas have brought their relatives with mental illness to be chained to the trees in the open spaces around the shrine. Here, they remain so tied through rain and shine, through the chilly winter nights and the blazing heat of summers for days, months and at times for years. The relatives of these patients chained to trees suffer no less. In many cases, having sold off all their belongings to bear the expenses, they often serve as domestic servants of the shrine managers, all the time waiting hopelessly for a cure through the courtesy of the Saint.

The overall picture resembles that of a zoo, except for the inmates who are humans on display tied up to trees. Ironically, the animals here roam free.

Taking the first steps

It was in 1991 when we first visited the shrine 300 miles south of Lahore. We had earlier heard vague stories about the place but assuming they were gross exaggerations and too painful to be true, we decided to visit to gain firsthand information. What we saw was much worse than what we had heard. The sight of patients with mental illness tied to trees by chains, like animals, was shocking. We saw patients of all ages, from children as young as 8 years to the elderly in their late 60s, helplessly tied to trees with metal chains. We later discovered that the chains were obtained on rent from the caretakers of the shrine, who also charged a certain fee for allocating a tree to be used for tying the unfortunate patient. While some patients had been tied for weeks and months, there were others who had been there for years. One young man had been there for nearly 10 years. His elderly mother had given up everything to spend all her time looking after her son. Tragically, when we met her she, like her son, had also developed a psychiatric illness.

The caretakers of the shrine proudly informed us that thousands upon thousands of patients with mental illness had been 'cured' through the blessings of the Saint and that this practice had been in force for over nine centuries.

As we moved from one tree to another, closely watching the patients tied to them, we could clearly see that almost all of them were suffering from an identifiable psychotic illness that could be promptly treated with appropriate medication. Finding the whole situation so appalling, we made a video recording of all that we saw. We started our journey home feeling extremely sad and distressed. We had witnessed unbelievable tragic scenes and throughout the journey their images kept recurring. By the time we reached Lahore, our home town, we had made up our minds: something had to be done to provide relief to these unfortunate people.

Initially we were unsure of how to make a beginning. It seemed an insurmountable task. Gradually, however, as we recovered from the initial impact, we started to focus on practical strategies that we could utilise to achieve our aims.

We started by setting up a charity organisation with some of our students and staff members of the department promptly joining in. We started a fund-raising campaign and through charity shows and help from private patients, rich friends and relatives we collected enough funds to set up a small clinic in the close vicinity of the shrine. For this, we had to be exceptionally tactful. As a starting point we openly announced that the medicines and injections that we were prescribing had the 'blessings of the Saint' and carried 'holy flavour'. This acted as a catalyst and prompted unexpected compliance. Every morning, one of our doctors went on a round. The round was literally taking a round of the trees to which patients were tied up. We still remember the first day when we had to take a psychiatric history and

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special articles

record mental state examination of a patient while sitting under the shade of the tree to which he was tied with a heavy metal chain. This was a completely new experience, as it would have been for anyone who, like us, had been accustomed to interviewing patients in the usual setting of a comfortable psychiatric clinic.

As the effect of medication began to show positive results, everyone saw the patients recovering earlier than ever before. The chains finally started coming off. With a view to avoid any chance of confrontation with the local caretakers of the shrine we continued to maintain a low profile, ensuring all along, however, that the patients continued to receive their medication and were provided adequate guidance in this regard. Follow-up visits were arranged and since all medication was provided free, almost every patient made sure to return to obtain a fresh supply of drugs. A 2 to 4 weekly follow-up was maintained and this allowed us to monitor the side-effects and adjust doses as necessary. On account of the commonly seen disorders, our drug therapy mostly comprised of antipsychotics, antidepressants and anti-convulsants.

Patient population and diagnostic categories

Despite the prevailing primitive conditions we were able to gather basic data on 100 patients who were new to the shrine during the early stages of our work. Each patient was assessed using a semi-structured interview and a final diagnosis was recorded using the *ICD–10 Classification of Mental & Behavioural Disorders* (World Health Organization, 1992).

As Table 1 shows, the ages of the patients ranged from under 9 years to those above 70 years, with the maximum numbers (approximately 50%) in the age range of 10–29 years. Males and females were roughly equally represented.

Table 2 shows the diagnostic categories according to ICD–10. Most common conditions seen were schizophrenia, epilepsy and depressive disorder. The table also highlights the differences in gender distribution of various disorders.

Although we were working in the most primitive circumstances, all efforts were made to ensure that the latest trends in pharmacotherapy practice were followed to the maximum. Patients who had complicated problems or needed sophisticated investigations were promptly transported to our own teaching department at Lahore (Department of Psychiatry, Fatima Jinnah Medical College, and Sir Ganga Ram Hospital), where further evaluations were undertaken.

We calculated that for a sum of as little as US$10 per month, we could manage a patient with schizophrenia in the community on long-term drug therapy. Through our fund-raising campaigns we were able to register donors who were prepared to sponsor the treatment of specific patients. In this way these donors, apart from providing financial help, were able to be involved in a more meaningful way with the patients they were helping.

It was always a moving sight to see patients who had been bound in chains and were suffering from treatable conditions walking away leaving the chains behind, within a fortnight.

Table 1. Age and sex distribution of patients

Age	Male *n*=48 (%)	Female *n*=52 (%)	Total *n*=100
0–9	8 (16.6)	4 (7.7)	12
10–19	16 (33.3)	13 (25.0)	29
20–29	11 (22.9)	11 (21.1)	22
30–39	4 (8.3)	5 (9.7)	9
40–49	3 (6.3)	11 (21.1)	14
50–59	2 (4.2)	– –	2
60–69	3 (6.3)	4 (7.7)	7
70–79	1 (2.1)	4 (7.7)	5

Comments

Our overall experience has shown us how therapeutically rewarding it can be to reach the unreached, untreated and unserved psychiatric patients languishing in our rural areas. We have also discovered that rather than blaming

Table 2. Frequency of ICD–10 diagnostic categories in patients

Diagnosis	Male *n*=48 (%)	Female *n*=52 (%)	Total *n*
F20 – Schizophrenia	8 (16.6)	11 (21.1)	19
G40 – Epilepsy	11 (22.9)	8 (15.4)	19
F32,33 – Depressive episode, recurrent depressive disorder	3 (6.3)	15 (28.8)	18
F7 – Moderate mental retardation	2 (4.2)	7 (13.5)	9
F31 – Bipolar affective disorder	5 (10.4)	3 (5.8)	8
F30 – Manic episode	7 (14.6)	–	7
F41.1 – Generalised anxiety disorder	2 (4.2)	3 (5.8)	5
F11,12 – Mental and behavioural disorders owing to use of opioids/cannabinoids	4 (8.3)	–	4
Dementia in Alzheimer's disease	1 (2.1)	1 (1.9)	2
Others[1]	5 (10.4)	4 (7.7)	9

1. Other diagnoses were: F44 – dissociative disorder; F40.0 – agoraphobia; F45.2 – hypochondriacal disorder; F43.0 – acute stress reaction; F25 – Schizoaffective disorder; F90 – hyperkinetic disorder; F42 – obsessive–compulsive disorder; G43 – migraine; and G00 – bacterial meningitis, not elsewhere classified.

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the government, politicians, bureaucracy or fate (all very common in our setting) for all the ills, it is far more fruitful to initiate effort and start improving conditions, even if on a small scale. Perhaps what we most lack in our social setting is the spirit, motivation, perseverance and dedication to bring about a change, and all these need to come from within.

We believe that it is better to light a small candle than to curse darkness. Our work at the shrine of Diwan Sahib has shown us that this is just the end of the beginning. There are countless people with mental illness in other parts of the country who are receiving no better care and need to be approached. The journey of a thousand miles begins with a single step and we think we have taken that first step. Despite all the opposition and temporary set-backs our spirits remain high and we are currently in the process of expanding our work to other remote areas of the country.

> "There is a loftier ambition than to merely stand high in the world. It is to step down and lift mankind a little higher."

Reference

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ANONYMOUS

That 'praecox feeling'

I've worked in psychiatry now for over a decade but never have I experienced that 'praecox feeling' with such certainty and dread as I did with Alyson.

Alyson, now in her mid-30s, is an arts graduate, an attractive woman who retains an interest in music and literature. She is from a large professional Roman Catholic family, financially sound and apparently supportive.

Alyson is my sister-in-law.

When we first met I was a senior house officer in psychiatry, inexperienced at work and naïve in many aspects of life. My partner, at that time, had ambitions about a career, a family and security. I wanted to share and contribute to this future but I always lived with the anxiety of that 'praecox feeling'.

At that time there was no diagnosis for Alyson. She was unemployed and drifting. Her family cared enormously, encouraging her to sit postgraduate exams and pursue work, but with repeated failures and rejections the undermining and cynicisms insidiously evolved. She would present unexpectedly at one of the family homes, dishevelled, penniless and vague. Confusion was paramount. After a bath, clean clothes and a meal the issues surrounding her appearance were never addressed.

Over the years the family gradually split. The 'lazy' camp disengaged, wanting nothing to do with her until she 'pulled herself together'. The 'ill camp' wanted her admitted to hospital and labelled – anything less was perceived as 'doing nothing'. So the family, previously supportive and caring, were now perceived as critical, over-involved or hostile.

She was advised to separate from that critical part of the family for her own survival. Survival for her now means day hospital attendance, a bedsit and a community psychiatric nurse. She is ravaged by illness, the course and development of which has been so insidious that it has defied both family and professional recognition for 15 years. Her superior intelligence facilitated on-going education despite decline in personality, relationships and coping strategies. Her articulate and distressed family have fought hard against a diagnosis they feel unable to accept. And the profession have colluded, waiting patiently until her whole demeanour is so fragmented, just a small part remains – so little to remind one of the beautiful child within.

And myself?

Well I have risen steadily through the ranks of training in psychiatry. I have my family – a partner and two small and perfect children. I have my security – in part.

But my fears and regrets are many fold. I too remained detached – dreading being dragged into in-law family feuds and having to take sides or give advice. She has professionals to do that, I rationalised. I have never volunteered my opinions but always wondered why no one asked – my training is no secret.

I feared for my partner. Was there a chance of illness presenting there? No I think age is on our side. But mostly I live with the fear for my children. That small but important increased risk, that 'positive family history'. I endeavour to look for differences between them and Alyson – looks, colouring, personality – anything, however irrational, that will reassure me of their differences. At the same time, I work each day with young people with schizophrenia, with their families, with their grief and loss. I admire their profound courage and resilience in the face of such cruel illness. I pray that I too will find the strength to support and nurture my own children should fate and heritage ever strike them such an unfair blow.

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